Mother's Name or Imprint: Baby's Name or Imprint:

MODULE 1 - PRENATAL INFORMATION - TO BE COMPLETED UPON ADMISSION TO THE HOSPITAL (MAY BE COLLECTED BY PRENATAL CARE PROVIDER AND REVIEWED AT HOSPITAL)

1. MOTHER'S DATE OF BIRTH
   ___ / ___ / ___
   Mo. Day Yr.

2. DATE OF LAST NORMAL MENSES
   ___ / ___ / ___
   Mo. Day Yr.

3. WHAT MONTH OF PREGNANCY WAS PRENATAL CARE BEGUN? (1,2,3, etc.; None=00)

4. WHERE DID THE MOTHER GET PRENATAL CARE? (Check all that apply)
   - 01 ☐ Private Practitioner
   - 02 ☐ HMO or Health Plan
   - 03 ☐ HealthStart
   - 04 ☐ Community Health Center
   - 05 ☐ GardenState
   - 06 ☐ Hospital's Clinic
   - 07 ☐ Other Clinic
   - 08 ☐ Other, Specify: _____
   - 00 ☐ None
   - 10 ☐ Unknown

5. PREGNANCY HISTORY

a. Gravid - What number pregnancy is this?

b. What is the total number of previous live births?

c. How many of the previous live births are now living?

d. How many of the previous live births are now dead?

e. What is the date of the last live birth?
   ___ / ___
   Mo. Yr.

f. What is the total number of previous pregnancy losses (miscarriages, spontaneous or induced abortions)?

g. What is the date of the last previous pregnancy loss?
   ___ / ___
   Mo. Yr.

h. Did patient have prior history of caesarean section? ☐Yes ☐No

6. RISK FACTORS PRESENT DURING PREGNANCY

A. Tobacco Use:	☐Yes	☐No	If Yes, _____ #/Day
	☐Yes, But Since Cut Down	☐Unknown	
	☐Yes, But Since Quit		
B. Alcohol Use:	☐Yes	☐No	If Yes, _____ #/Week
	☐Yes, But Since Cut Down	☐Unknown	
	☐Yes, But Since Quit		
C. Cocaine, Heroin, Marijuana or Methamphetamines Use:	☐Yes	☐No	
	☐Yes, But Since Cut Down	☐Unknown	
	☐Yes, But Since Quit		

7. HEPATITIS B SEROLOGY OBTAINED ☐Yes ☐No ☐Unknown

8. SYPHILIS SEROLOGY OBTAINED ☐Yes ☐No ☐Unknown

9. IF YES, SYPHILIS SEROLOGY DATE
   ___ / ___ / ___
   Mo. Day Yr.

10. MOTHER'S BLOOD TYPE ☐A ☐B ☐O ☐AB

11. RH ☐Positive ☐Negative

12. OBSTETRIC PROCEDURES DURING PREGNANCY
   - 01 ☐ CVS
   - 02 ☐ Ultrasound
   - 03 ☐ Amniocentesis (Genetic)
   - 04 ☐ Amniocentesis (Other)
   - 05 ☐ Tocolysis
   - 15 ☐ Unknown
   - 00 ☐ None

13. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)
   - 01 ☐ Anemia (Hct<30 / Hgb<10)
   - 02 ☐ Cardiac Disease
   - 03 ☐ Coma
   - 04 ☐ Diabetes, Insulin Dependent-Preexisting
   - 05 ☐ Diabetes, Non-Insulin Dependent-Preexisting
   - 06 ☐ Diabetes, Gestational
   - 07 ☐ Eclampsia
   - 08 ☐ Genital Herpes
   - 09 ☐ Hemoglobinopathy
   - 10 ☐ Hepatitis B S Ag Pos
   - 11 ☐ Hydraminos/Oligohydraminos
   - 12 ☐ Hypertension, Chronic
   - 13 ☐ Hypertension, Pregnancy Related
   - 14 ☐ Incompetent Cervix
   - 15 ☐ Lung Disease, Acute or Chronic
   - 16 ☐ Preeclampsia
   - 17 ☐ Previous Infant 4000+ Grams
   - 18 ☐ Previous Major Uterine Surgery
   - 19 ☐ Previous Preterm or Small-for-Gestational-Age Infant
   - 20 ☐ Renal Disease
   - 21 ☐ RH Sensitization
   - 22 ☐ Other Isoimmunization
   - 23 ☐ Seizures
   - 24 ☐ Other Sexually Transmitted Diseases, Specify: _____
   - 25 ☐ Syphilis Serology Positive
   - 26 ☐ Uterine Bleeding
   - 27 ☐ Other, Specify: _____
   - 28 ☐ Unknown
   - 00 ☐ None

14. DATE OF ADMISSION
   ___ / ___ / ___
   Mo. Day Yr.

15. TOTAL NUMBER OF PRENATAL VISITS

16. WEIGHT GAIN DURING PREGNANCY _____ Lbs.

17. Was this information collected by the prenatal care provider and reviewed at the hospital? ☐Yes ☐No

18. Were any changes necessary? ☐Yes ☐No

19. Was the prenatal medical record available when completing this section? ☐Yes ☐No

Name of Individual Completing This Module	Signature	Date